Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Newborn to 1 Week Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

Gestational age_____ Maternal labs_____
Complications_____
Birth history ☐ NSVD ☐ C-section Breech ☐ Yes ☐ No
Birth weight_____ Discharge weight_____
Newborn metabolic screen ☐ NL
Newborn bilirubin screen ☐ NL
Newborn critical congenital heart disease pulse oximetry _____
Newborn hearing screen ☐ Pass ☐ Fail ☐ Pending ☐ Retest

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care plans? _____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child has periods of wakefulness ☐ Child looks at and studies you when awake ☐ Child looks in your eyes when being held ☐ Child calms when picked up ☐ Child responds differently to soothing touch and alerting touch
Verbal Language ☐ Child communicates discomfort through crying, facial expressions and body movements ☐ Child moves or calms to your voice
Gross Motor ☐ Child moves in response to visual or auditory stimuli ☐ Child moves arms and legs symmetrically and reflexively when startled ☐ Child lifts head briefly when on stomach and can turn it to the side
Fine Motor ☐ Child keeps hands in fist ☐ Child automatically grasps others' fingers or objects
Concerns and/or questions_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

General Health

☐ Growth plotted on growth chart
Do you think your child sees okay? ☐ Yes ☐ No

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Place on back to sleep_____
Concerns and/or questions_____

_____

_____

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Umbilical cord	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Jaundice ☐ Yes ☐ No
Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions _____

_____

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Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Living situation and food security
- ☐ Environmental tobacco exposure
- ☐ Intimate partner violence
- ☐ Maternal alcohol and substance use
- ☐ Family Support
- ☐ Parent(s)-newborn relationship

Parental/Family Health and Well-being
- ☐ Maternal health and nutrition
- ☐ Transitioning home
- ☐ Sibling adjustments/relationships

Newborn Behavior and Care
- ☐ Baby care (infant supplies, skin, and cord care)
- ☐ Illness prevention (hand washing, outings and sun protection)
- ☐ Calming your baby
- ☐ Early brain development (singing, talking and reading to child)
- ☐ Emergency care

Nutrition and Feeding
- ☐ General guidance on feeding
- ☐ Breastfeeding guidance
- ☐ Formula feeding guidance

Safety
- ☐ Car seat safety
- ☐ Heatstroke prevention
- ☐ Safe sleep
- ☐ Pets
- ☐ Safe home environment

☐ **Other**

_____

Questions/Concerns/Notes

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs_____

Referrals ☐ Developmental

☐ Other _____

- ☐ Right from the Start (RFTS)**1-800-642-9704**
- ☐ Birth to Three (BTT)**1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC)**1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 1 month of age ☐ 2 months of age

☐ Other_____

☐ **Screen has been reviewed and is complete**

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

By 1 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen
Birth weight_____ Discharge weight_____
Newborn metabolic screen ☐ NL ☐ Results in child's record
Newborn bilirubin screen ☐ NL ☐ Results in child's record
Newborn critical congenital heart disease pulse oximetry _____
☐ Results in child's record
Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____
☐ Results in child's record
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family's living situation?_____
_____
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____
_____
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Who do you contact for help and/or support?_____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care plans? _____
How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Maternal Depression/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Little interest or pleasure in doing things
☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2)
☐ Nearly every day(3)
Feeling down, depressed, or hopeless
☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2)
☐ Nearly every day(3)
Concerns and/or questions_____
_____
_____

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child looks at you and follows you with his/her eyes ☐ Child has self-comforting behaviors, such as bringing hands to mouth ☐ Child becomes fussy when bored ☐ Child calms when picked up or spoken to
Verbal Language (Expressive and Receptive) ☐ Child makes brief short vowel sounds ☐ Child alerts to unexpected sounds ☐ Child quiets and turns to your voice ☐ Child shows signs of sensitivity to environment (excessive crying, tremors, excessive startles)
☐ Child has different types of cries for hunger and tiredness
Gross Motor ☐ Child moves both arms and legs together
☐ Child can hold chin up when on stomach
Fine Motor ☐ Child can open fingers slightly when at rest
Concerns and/or questions_____
_____
_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
Concerns and/or questions_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
Do you think your child sees okay? ☐ Yes ☐ No
Do you think your child hears okay? ☐ Yes ☐ No

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Normal sleeping patterns_____
☐ Place on back to sleep_____
☐ Sleeps 3 to 4 hours at a time_____
☐ Can stay awake for 1 hour or longer_____
Concerns and/or questions_____
_____
_____

See Periodicity Schedule for Risk Factors

***Tuberculosis Risk**
☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Living situation and food security
- ☐ Environmental tobacco exposure
- ☐ Dampness and mold
- ☐ Radon
- ☐ Pesticides
- ☐ Intimate partner violence
- ☐ Maternal alcohol and substance abuse
- ☐ Family support/help

Parental/Family Health and Well-being
- ☐ Postpartum checkup
- ☐ Maternal depression
- ☐ Family relationships

Infant Behavior and Development
- ☐ Sleeping and waking
- ☐ Fussiness and attachment
- ☐ Media (distract from child's care)
- ☐ Playtime
- ☐ Medical home after hours support

Nutrition and Feeding
- ☐ Feeding plans and choices
- ☐ General guidance on feeding
- ☐ Breastfeeding guidance
- ☐ Formula feeding guidance

Safety
- ☐ Car seat safety
- ☐ Safe sleep
- ☐ Preventing falls (changing table, couch, bed)
- ☐ Emergency care (CPR)

☐ **Other**

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ TB skin test *(if high risk)*
- ☐ Other

_____

_____

Referrals ☐ Maternal depression - **Help4WV.com/1-844-435-7498**
- ☐ Developmental
- ☐ Other _____

- ☐ Right from the Start (RFTS) **1-800-642-9704**
- ☐ Birth to Three (BTT) **1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 2 months of age

☐ Other_____

☐ **Screen has been reviewed and is complete**

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

2 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Newborn metabolic screen ☐ NL ☐ Results in child's record
Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____
☐ Results in child's record

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

☐ **Family health history reviewed** _____
_____

Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family's living situation?_____
_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____
_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____

Who do you contact for help and/or support?_____
_____

Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care plans? _____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Sever
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____
_____

Maternal Depression/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Little interest or pleasure in doing things
☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)
Feeling down, depressed, or hopeless
☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child smiles responsively ☐ Child makes sounds that let you know if he/she is happy
Verbal Language (Expressive and Receptive) ☐ Child makes short cooing sounds
Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position
Fine Motor ☐ Child can open and shut hands ☐ Child can briefly bring hands together
Concerns and/or questions_____
_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No
Do you think your child hears okay? ☐ Yes ☐ No

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Normal sleeping patterns_____
☐ Place on back to sleep_____
☐ Sleeps 3 to 4 hours at a time_____
Concerns and/or questions_____
_____

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Living situation and food security
- ☐ Family support
- ☐ Child care

Parental/Family Health and Well-being
- ☐ Postpartum checkup
- ☐ Depression
- ☐ Sibling relationships

Infant Behavior and Development
- ☐ Parent - infant relationship
- ☐ Parent - infant communication
- ☐ Sleeping
- ☐ Media
- ☐ Playtime
- ☐ Fussiness

Nutrition and Feeding
- ☐ General guidance on feeding and delaying solid foods
- ☐ Hunger and satiety cues
- ☐ Breastfeeding guidance
- ☐ Formula-feeding guidance

Safety
- ☐ Car seat safety
- ☐ Safe sleep
- ☐ Safe home environment (burns, drowning, and falls)

☐ **Other**

_____

Questions/Concerns/Notes

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs_____

Referrals ☐ Maternal depression - **Help4WV.com/1-844-435-7498**
- ☐ Developmental
- ☐ Other _____

- ☐ Right from the Start (RFTS) **1-800-642-9704**
- ☐ Birth to Three (BTT) **1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 4 months of age

☐ Other_____

☐ **Screen has been reviewed and is complete**

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

4 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

_____

Maternal Depression/Patient Health Questionnaire (PHQ-2)

Positive screen = numbered responses 3 or greater

If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Little interest or pleasure in doing things

☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Concerns and/or questions_____

_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ Child can laugh out loud ☐ Child can look for you or another caregiver when upset

Verbal Language (Expressive and Receptive) ☐ Child can turn to voices ☐ Child can make extended cooing sounds

Gross Motor ☐ Child can support himself/herself on elbows and wrists when on stomach ☐ Child can roll over from stomach to back

Fine Motor ☐ Child can keep his/her hands unfisted ☐ Child can play with fingers in midline ☐ Child can grasp objects

Concerns and/or questions_____

_____

_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____ Frequency_____

☐ Formula _____

☐ Juice ☐ Water

☐ Has started solid foods ☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

☐ Place on back to sleep_____

Concerns and/or questions_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Environmental risk (lead)
- ☐ Family relationships and support
- ☐ Child care

Infant Behavior and Development
- ☐ Infant self-calming
- ☐ Parent-infant communication
- ☐ Consistent daily routines
- ☐ Media
- ☐ Playtime

Oral Health
- ☐ Maternal oral health
- ☐ Teething and drooling
- ☐ Good oral hygiene (no bottle in bed)

Nutrition and Feeding
- ☐ General guidance on feeding
- ☐ Feeding choices (avoid grazing)
- ☐ Delaying solid foods
- ☐ Breastfeeding guidance
- ☐ Supplements and over-the-counter medications
- ☐ Formula feeding guidance

Safety
- ☐ Car safety seats
- ☐ Safe sleep
- ☐ Safe home environment

☐ **Other**

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ Other

_____

_____

Referrals ☐ Maternal depression - **Help4WV.com/1-844-435-7498**
- ☐ Developmental
- ☐ Other _____

☐ Right from the Start (RFTS) **1-800-642-9704**
☐ Birth to Three (BTT) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 6 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

6 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Maternal Depression/Patient Health Questionnaire (PHQ-2)

Positive screen = numbered responses 3 or greater

If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Little interest or pleasure in doing things

☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Concerns and/or questions_____

_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ Child can pat or smile at his/her reflection ☐ Child can look when you call his/her name

Verbal Language (Expressive and Receptive) ☐ Child can babble ☐ Child can make sounds like "ga", "ma", or "ba"

Gross Motor ☐ Child can roll over from back to stomach ☐ Child can sit briefly without support

Fine Motor ☐ Child can pass a toy from one hand to another ☐ Child can rake small objects with 4 fingers ☐ Child can bang small objects on surface

Concerns and/or questions_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Tooth eruption ☐ Yes ☐ No

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____ Frequency_____

☐ Formula _____

☐ Juice ☐ Water

☐ Has started solid foods ☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

☐ Place on back to sleep_____

Concerns and/or questions_____

_____

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

See Periodicity Schedule for Risk Factors

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Living situation and food security
☐ Tobacco, alcohol, and drugs
☐ Parental depression
☐ Family relationships and support
☐ Child care

Infant Behavior and Development
☐ Parents as teachers
☐ Community and early literacy
☐ Media
☐ Emerging infant independence
☐ Putting self to sleep
☐ Self-calming

Oral Health
☐ Fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed

Nutrition and Feeding
☐ General guidance on feeding
☐ Solid foods
☐ Pesticides in vegetables and fruits
☐ Fluids and juice
☐ Breastfeeding guidance
☐ Formula-feeding guidance

Safety
☐ Car safety seats
☐ Safe sleep
☐ Safe home environment (burns, sun exposure, choking, poisoning, drowning, falls)

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Other

Referrals ☐ Maternal depression - **Help4WV.com/1-844-435-7498**
☐ Developmental
☐ Other _____

☐ Right from the Start (RFTS) **1-800-642-9704**
☐ Birth to Three (BTT) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 9 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

9 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Tooth eruption ☐ Yes ☐ No

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____Frequency_____

☐ Formula _____

☐ Juice ☐ Water

☐ Has started solid foods ☐ Table foods ☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

☐ Place on back to sleep_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Lead Risk**

☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Intimate partner violence
- ☐ Family relationships and support

Infant Behavior and Development
- ☐ Changing sleep pattern (sleep schedule)
- ☐ Developmental mobility and cognitive development
- ☐ Interactive learning and communication
- ☐ Media

Discipline
- ☐ Parent expectations of child's behavior

Nutrition and Feeding
- ☐ Self-feeding, mealtime routines, transition to solid foods (table food introduction), cup drinking
- ☐ Plans for weaning

Safety
- ☐ Car safety seats
- ☐ Heatstroke prevention
- ☐ Firearm safety
- ☐ Safe home environment (burns, poisoning, drowning, falls)

☐ **Other**

_____

Questions/Concerns/Notes

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ Blood lead *(if high risk) (enter into WVSIIS)*
- ☐ Other

_____

_____

Referrals
- ☐ Developmental
- ☐ Other _____

- ☐ Right from the Start (RFTS) **1-800-642-9704**
- ☐ Birth to Three (BTT) **1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 12 months of age

☐ Other_____

☐ **Screen has been reviewed and is complete**

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

12 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can protoimperative point (point to request an object) ☐ Child can imitate new gestures ☐ Child can look for hidden objects

Verbal Language (Expressive and Receptive) ☐ *Child can babble ☐ *Child can imitate vocalizations and sounds ☐ Child can use "Dada" or "Mama" specifically ☐ Child can use 1 word other than "Mama," "Dada," or personal name

Gross Motor ☐ Child can take first independent steps ☐ Child can stand without support

Fine Motor ☐ Child can drop an object in a cup ☐ Child can pick up small objects with 2 finger pincer grasp ☐ Child can pick up food and eat it

Absence of these milestones = Autism Screen

Concerns and/or questions_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

Concerns and/or questions_____

_____

_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Dental referral required at 12 months

Tooth eruption ☐ Yes ☐ No

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____ Frequency_____

☐ Formula _____

Plans for weaning_____

☐ Milk ☐ Juice ☐ Water

☐ Has started solid foods ☐ Table foods ☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

Hemoglobin/hematocrit required at 12 months

***Lead Risk**

Blood lead required at 12 months

***Tuberculosis Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Fontanelles	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Living situation and food security
- ☐ Tobacco, alcohol, and drugs
- ☐ Social connections with family, friends, child care, home visitation program staff, and others

Establishing Routines
- ☐ Adjustment to child's developmental changes and behavior
- ☐ Family time
- ☐ Bedtime, naptime, and teeth brushing
- ☐ Media

Feeding and Appetite Changes
- ☐ Self-feeding
- ☐ Continued breastfeeding and transition to family meals
- ☐ Nutritious foods

Establishing a Dental Home
- ☐ First dental checkup and dental hygiene

Safety
- ☐ Car safety seats
- ☐ Falls
- ☐ Drowning prevention and water safety
- ☐ Sun protection
- ☐ Pets
- ☐ Safe home environment: poisoning

☐ Other

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ **Hemoglobin/hematocrit** *(required at 12 months)*
- ☐ **Blood lead** *(required at 12 months) (enter into WVSIIS)*
- ☐ TB skin test *(if high risk)*
- ☐ Other

_____

_____

Referrals

☐ Developmental ☐ **Dental** ☐ Blood lead ≥5ug/dl

☐ Other _____

_____

☐ Birth to Three (BTT) **1-800-642-9704**

☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 15 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

15 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can prodeclarative point (point to comment on an interesting object/event-will look alternatively between object/event and parent) ☐ Child can point to ask for something to get help ☐ Child can look around when you say things like "Where's your ball?" or "Where's your blanket?" ☐ Child can imitate scribbling ☐ Child can drink from a cup with little spilling

Verbal Language (Expressive and Receptive) ☐ Child can use 3 words other than names ☐ Child can speak in sounds like an unknown language ☐ Child can follow directions that do not include a gesture

Gross Motor ☐ Child can squat to pick up objects ☐ Child can crawl up a few steps ☐ Child can run

Fine Motor ☐ Child can make marks with a crayon ☐ Child can drop an object in and take object out of a container

Absence of these milestones = Autism Screen

Concerns and/or questions_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

Concerns and/or questions_____

_____

_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____ Frequency_____

☐ Formula _____

Plans for weaning_____

☐ Milk ☐ Juice ☐ Water

☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Lead Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Communication and Social Development
- ☐ Individuation
- ☐ Separation
- ☐ Finding support
- ☐ Attention to how child communicates wants and interests

Sleep Routines and Issues
- ☐ Regular bedtime routine, night waking, no bottle in bed

Temperament, Development, Behavior, and Discipline
- ☐ Conflict predictors and distraction
- ☐ Discipline and behavior management

Healthy Teeth
- ☐ Brushing teeth
- ☐ Reducing caries

Safety
- ☐ Car safety seats and parental use of seat belts
- ☐ Safe home environment: poisoning, falls, and fire safety

☐ Other

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ Blood lead *(if high risk) (enter into WVSIIS)*
- ☐ Other _____

Referrals
- ☐ Developmental ☐ Dental
- ☐ Other _____
- ☐ Birth to Three (BTT) **1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 18 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

18 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Concerns and/or questions_____

_____

_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Breastfeeding - Frequency _____

☐ Bottle feeding - Amount_____ Frequency_____

☐ Formula _____

Plans for weaning_____

☐ Milk ☐ Juice ☐ Water

☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Lead Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Temperament, Development, Toilet Training, Behavior and Discipline

- ☐ Anticipation of return to separation anxiety and managing behavior with consistent limits
- ☐ Recognizing signs of toilet training and readiness and parental expectations
- ☐ New sibling planned or on the way

Communication and Social Development

- ☐ Encouragement of language, use of simple words and phrases, encouragement in reading, playing, talking, and singing

Television Viewing and Digital Media

- ☐ Promotion of reading, physical activity and safe play

Healthy Nutrition

- ☐ Nutritious foods
- ☐ Water, milk, juice
- ☐ Expressing independence through food likes and dislikes

Safety

- ☐ Car safety seats and parental use of seat belts
- ☐ Sun protection
- ☐ Firearm safety
- ☐ Safe home environment: burns, fires, and falls

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ Blood lead *(if high risk) (enter into WVSIIS)*
- ☐ Other _____

Referrals

- ☐ Developmental ☐ Dental
- ☐ Other _____

- ☐ Birth to Three (BTT) **1-800-642-9704**
- ☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
- ☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 24 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

24 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height _____ BMI_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

☐ Child can play alongside other children, also called parallel play ☐ Child can take off some clothing ☐ Child can scoop well with a spoon ☐ Child can use 50 words ☐ Child can combine 2 words into short phrase or sentence ☐ Child can follow 2-step command ☐ Child can name at least 5 body parts, such as nose and hand ☐ Child's speech is 50% understandable to strangers ☐ Child can kick a ball ☐ Child can jump off the ground with 2 feet ☐ Child can run with coordination ☐ Child can climb up a ladder at a playground ☐ Child can stack objects ☐ Child can turn book pages ☐ Child can use his/her hands to turn objects like knobs, toys, and lids ☐ Child can draw a line

Concerns and/or questions_____

_____

_____

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Do you utilize a car seat for your child? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Concerns and/or questions_____

_____

_____

_____

_____

_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Normal eating habits

Fruits/vegetables/lean protein per day_____

☐ Vitamins

☐ Normal elimination_____

Toilet trained ☐ Yes ☐ No

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

Concerns and/or questions_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Lead Risk**

Blood lead required at 24 months

***Tuberculosis Risk**

☐ Low risk ☐ High risk

***Dyslipidemia Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Intimate partner violence
- ☐ Living situation and food security
- ☐ Tobacco, alcohol, and drugs
- ☐ Parental well-being

Temperament and Behavior
- ☐ Development
- ☐ Temperament
- ☐ Promotion of physical activity and safe play
- ☐ Limits on media use

Assessment of Language Development
- ☐ How child communicates and expectations for language
- ☐ Promotion of reading

Toilet Training
- ☐ Techniques
- ☐ Personal hygiene

Safety
- ☐ Car safety seats
- ☐ Outdoor safety
- ☐ Firearm safety

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ **Blood lead** *(required at 24 months) (enter into WVSIIS)*
- ☐ TB skin test *(if high risk)*
- ☐ Lipid profile *(if high risk)*
- ☐ Other _____

Referrals
- ☐ Developmental ☐ Dental ☐ Blood lead ≥5ug/dl
- ☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
- ☐ Other _____

☐ Birth to Three (BTT) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 30 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

30 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Do you utilize a car seat for your child? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Concerns and/or questions_____

_____

_____

_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied *(apply every 3 to 6 months)*

☐ Yes ☐ No _____

Nutrition/Sleep

☐ Normal eating habits

Fruits/vegetables/lean protein per day_____

☐ Vitamins _____

☐ Normal elimination_____

Toilet trained ☐ Yes ☐ No

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

Concerns and/or questions_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Lead Risk**

☐ Low risk ☐ High risk

***Tuberculosis Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Intimate partner violence
- ☐ Living situation and food security
- ☐ Tobacco, alcohol, and drugs
- ☐ Parental well-being

Temperament and Behavior
- ☐ Development
- ☐ Temperament
- ☐ Promotion of physical activity and safe play
- ☐ Limits on media use

Assessment of Language Development
- ☐ How child communicates and expectations for language
- ☐ Promotion of reading

Toilet Training
- ☐ Techniques
- ☐ Personal hygiene

Safety
- ☐ Car safety seats
- ☐ Outdoor safety
- ☐ Firearm safety

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
- ☐ TB skin test *(if high risk)*
- ☐ Other _____

Referrals
- ☐ Developmental ☐ Dental
- ☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
- ☐ Other _____

☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

☐ Women, Infants and Children (WIC) **1-304-558-0030**

☐ Birth to Three (BTT) transition planning

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 3 years of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

3 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen *(Subjective screen required)*
Do you think your child hears okay? ☐ Yes ☐ No
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and urinate by himself/herself ☐ Child can put on coat, jacket or shirt by themselves ☐ Child can eat independently ☐ Child can engage in imaginative play ☐ Child can play in cooperation and share ☐ Child can use 3 word sentences ☐ Child can speak in words that are 75% understandable to strangers ☐ Child can tell you a story from a book or TV ☐ Child can compare things using words like bigger or shorter ☐ Child can understand simple prepositions, such as on or under ☐ Child can pedal a tricycle ☐ Child can climb on and off couch or chair ☐ Child can jump forward ☐ Child can draw a single circle ☐ Child can draw a person with head and 1 other body part ☐ Child can cut with child scissors

☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704
☐ Women, Infants and Children (WIC) **1-304-558-0030**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Living situation and food security
☐ Tobacco, alcohol, and drugs
☐ Positive family interactions
☐ Work-life balance

Playing with Siblings and Peers
☐ Play opportunities and interactive games
☐ Sibling relationships

Encouraging Literacy Activities
☐ Reading, talking, and singing together
☐ Language development

Promoting Healthy Nutrition and Physical Activity
☐ Water, milk, and juice
☐ Nutritious foods
☐ Competence in motor skills and limits on inactivity

Safety
☐ Car safety seats
☐ Choking prevention
☐ Pedestrian safety and falls from windows
☐ Water safety
☐ Pets
☐ Firearm safety

☐ Other
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk)* *(enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Other
_____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 4 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

4 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@ ☐ UTO *(retest in 6 months)*
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and have a bowel movement by himself/ herself ☐ Child can brush his/her teeth ☐ Child can dress and undress without much help ☐ Child can engage in well-developed imaginative play ☐ Child can answer simple questions ☐ Child can speak in words that are 100% understandable to strangers ☐ Child can draw pictures that you recognize ☐ Child can follow simple rules when playing games ☐ Child can tell you a story from a book ☐ Child can skip on 1 foot ☐ Child can climb stairs, alternating feet, without support ☐ Child can draw a person with at least 3 body parts ☐ Child can draw a simple cross ☐ Child can unbutton and button medium sized buttons ☐ Child can grasp pencil with thumb and fingers instead of fist
☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704
☐ Women, Infants and Children (WIC) **1-304-558-0030**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____
_____
How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____
_____
_____
_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Living situation and food security
☐ Tobacco, alcohol, and drugs
☐ Intimate partner violence
☐ Safety in the community
☐ Engagement in the community

School Readiness
☐ Language understanding and fluency
☐ Feelings
☐ Opportunities to socialize with other children
☐ Readiness for structured learning experiences
☐ Early childhood programs and preschool

Developing Healthy Nutrition and Personal Habits
☐ Milk, water, and juice
☐ Nutritious foods
☐ Daily routines that promote health

Media Use
☐ Limits on use
☐ Promoting physical activity and safe play

Safety
☐ Belt-positioning car booster seats
☐ Outdoor safety
☐ Water safety
☐ Sun protection
☐ Pets
☐ Firearm safety

☐ Other
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 5 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

5 and 6 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(5 years, apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can balances on one foot, hops and skips
☐ Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles
☐ Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors
☐ Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance

☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____
_____
How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Child's grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk** *(year 6)*
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Neighborhood and family violence
☐ Food security
☐ Family substance use (tobacco, alcohol, drugs)
☐ Emotional security and self-esteem
☐ Connectedness with family

Developmental and Mental Health
☐ Family rules and routines
☐ Concern and respect for others
☐ Patience and control over anger

School
☐ Readiness
☐ Established routines and school attendance
☐ Friends
☐ After school care
☐ Parent - teacher communication

Physical Growth and Development
☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
☐ Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, healthy foods in school)
☐ Physical activity (60 minutes per day)

Safety
☐ Car safety
☐ Outdoor safety
☐ Water safety
☐ Sun protection
☐ Harm from adults (sexual abuse)
☐ Home fire safety
☐ Firearm safety

☐ Other
_____
_____
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(year 6, if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 6 years of age ☐ 7 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

7 and 8 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about behavior, speech, learning, social or motor skills_____
_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are parents/caregivers working outside home? ☐ Yes ☐ No
Child care/after school care _____
_____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Exposure to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Neighborhood and family violence (bullying, fighting)
☐ Food security
☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
☐ Harm from the internet
☐ Emotional security and self-esteem
☐ Connectedness with family and peers

Developmental and Mental Health
☐ Independence, rules and consequences, temper problems and conflict resolution
☐ Puberty and pubertal development

School
☐ Adaption to school, school problems (behavior or learning issues), school performance and progress, school attendance, individual education program or special education services, involvement in school activities and after-school programs

Physical Growth and Development
☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
☐ Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, limiting added sugars intake)
☐ Physical activity (60 minutes per day, screen time)

Safety
☐ Car safety
☐ Safety during physical activity
☐ Water safety
☐ Sun protection
☐ Harm from adults (physical/sexual abuse)
☐ Firearm safety

☐ Other

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other _____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 8 years of age ☐ 9 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

9 and 10 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial Screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family living situation_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Are parents/caregivers working outside home? ☐ Yes ☐ No

Child care/after school care _____

_____

Grade in school_____

Favorite subject_____

Any problems?_____

Activities outside school_____

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Concerns about behavior, speech, learning, social or motor skills_____

_____

_____

Concerns about moodiness or depression_____

_____

_____

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

Traumatic Stress Reactions/PCL-C[1]

Positive screen = numbered responses 4 or greater

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Risk Indicators (✓ *Check those that apply)*

Exposure to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No

Fruits/vegetables/lean protein per day_____

☐ Vitamins_____

☐ Normal elimination_____

☐ Physical activity/exercise an hour most days

Type of physical activity/exercise _____

Normal sleeping patterns? ☐ Yes ☐ No

Hours of sleep each night?_____

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 10 years)*

R _____ L _____

Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective 10 years)*

20db@

R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

Wears hearing aids? ☐ Yes ☐ No

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Tuberculosis Risk**

☐ Low risk ☐ High risk

***Dyslipidemia Risk**

☐ Low risk ☐ High risk

Fasting lipoprotein required once between 9 and 11 years

Continue on page 2

[1]Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594*. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34*, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N ☐ Abn	_____
Skin	☐ N ☐ Abn	_____
Neurological	☐ N ☐ Abn	_____
Reflexes	☐ N ☐ Abn	_____
Head	☐ N ☐ Abn	_____
Neck	☐ N ☐ Abn	_____
Eyes	☐ N ☐ Abn	_____
Ears	☐ N ☐ Abn	_____
Nose	☐ N ☐ Abn	_____
Oral Cavity/Throat	☐ N ☐ Abn	_____
Lung	☐ N ☐ Abn	_____
Heart	☐ N ☐ Abn	_____
Pulses	☐ N ☐ Abn	_____
Abdomen	☐ N ☐ Abn	_____

If female:

LMP_____ ☐ Regular ☐ Irregular

Bleeding ☐ Normal ☐ Heavy

Cramping ☐ No ☐ Slight ☐ Severe

Genitalia	☐ N ☐ Abn	_____
Back	☐ N ☐ Abn	_____
Hips	☐ N ☐ Abn	_____
Extremities	☐ N ☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health

- ☐ Neighborhood and family violence (fighting, bullying)
- ☐ Food security
- ☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
- ☐ Harm from the internet
- ☐ Emotional security and self esteem
- ☐ Connectedness with family and peers

Development and Mental Health

- ☐ Temper problems, setting reasonable limits, friends
- ☐ Sexuality (pubertal onset, personal hygiene, initiation of growth spurt, menstruation and ejaculation, loss of baby fat and accretion of muscles, sexual safety)

School

- ☐ School attendance, school problems (behavior or learning), school performance and progress, transitions, co-occurrence of middle school and pubertal transactions

Physical and Growth Development

- ☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
- ☐ Nutrition (healthy weight, disordered eating behaviors, importance of breakfast, limits on saturated fat and added sugars, healthy snacks)
- ☐ Physical activity (60 minutes per day, after school activities)

Safety

- ☐ Car safety
- ☐ Safety during physical activity
- ☐ Water safety
- ☐ Sun protection
- ☐ Knowing child's friends and their families
- ☐ Firearm safety

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ TB skin test *(if high risk)*
- ☐ **Fasting lipoprotein (*once between 9 and 11 years and/or high risk)***
- ☐ Other _____

Referrals

- ☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
- ☐ Dental ☐ Vision ☐ Hearing
- ☐ Other _____

☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 10 years of age ☐ 11 years of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

11, 12, 13 and 14 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 12 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 11 and 14 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about behavior, speech, learning, social and/or motor skills_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Family Planning (FP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are parents/caregivers working outside home? ☐ Yes ☐ No
Child care/after school care _____
Grade in school_____
Favorite subject_____
Any problems_____
Activities outside school_____

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help
☐ Financial ☐ Emotional loss ☐ Health insurance
☐ Other_____
_____
Concerns and/or questions_____
_____

Traumatic Stress Reactions/PCL-C[1]
Positive screen = numbered responses 4 or greater
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1)
☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)
Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1)
☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Depression Screen/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If Positive see Periodicity Schedule for link to PHQ-9
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Little interest or pleasure in doing things: ☐ Not at all ☐ Several days(1)
☐ More than ½ the days(2) ☐ Nearly every day(3)
Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days(1)
☐ More than ½ the days(2) ☐ Nearly every day(3)

Risk Indicators (✓ *Check those that apply)*

☐ None identified ☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes ☐ *Chew ☐ Passive Smoke Risk
☐ *Alcohol use_____
☐ *Drug use (prescription or otherwise)_____
If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA
Do you wear protective gear, including seat belts? ☐ Yes ☐ No

Continue on page 2

[1]Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594.* Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34*, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

☐ Excessive television/video game/internet/cell phone use

(13 and 14 years)
Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No
Are you sexually active? ☐ Yes ☐ No
Method of contraception _____
Do you have children? ☐ Yes ☐ No _____
_____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 9 and 11 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Interpersonal violence (fighting, bullying)
☐ Living situation and food security
☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
☐ Connectedness with family and peers
☐ Connectedness with community
☐ School performance
☐ Coping with stress and decision making

Physical Health and Health Promotion
☐ Oral health
☐ Body image
☐ Healthy eating
☐ Physical activity and sleep

Emotional Well-being
☐ Mood regulation and mental health
☐ Sexuality

Risk Reduction
☐ Pregnancy and sexually transmitted infections
☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
☐ Acoustic trauma

Safety
☐ Seat belt and helmet use
☐ Substance use and riding in a vehicle
☐ Firearm safety

☐ Other
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Fasting lipoprotein (*once between 9 and 11 years and/or high risk)*
☐ STI test *(if sexually active and/or high risk)*
☐ HIV test *(if sexually active and/or high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 12 years of age ☐ 13 years of age
☐ 14 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

15, 16 and 17 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ N/A ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 15 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 15 and 17 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about behavior, speech, learning, social and/or motor skills_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Family Planning (FP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your living situation?_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you still in school? ☐ Yes ☐ No Working? ☐ Yes ☐ No
What are your future plans?_____
_____
What interests do you have outside of school and/or work? _____
_____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help
☐ Financial ☐ Emotional loss ☐ Health insurance
☐ Other_____
_____
Concerns and/or questions_____
_____

Traumatic Stress Reactions/PCL-C[1]
Positive screen = numbered responses 4 or greater
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)
Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Depression Screen/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If Positive see Periodicity Schedule for link to PHQ-9
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Little interest or pleasure in doing things: ☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)
Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Risk Indicators (✓ *Check those that apply)*

☐ None identified ☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes ☐ *Chew ☐ Passive Smoke Risk
☐ *Alcohol use_____
☐ *Drug use (prescription or otherwise)_____
If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Continue on page 2

[1]Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594.* Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34*, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No
Are you sexually active? ☐ Yes ☐ No
Method of contraception _____
Do you have children? ☐ Yes ☐ No _____
_____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 17 and 20 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV Risk**
☐ Low risk ☐ High risk
HIV test required once between 15 and 18 years

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N ☐ Abn	_____
Skin	☐ N ☐ Abn	_____
Neurological	☐ N ☐ Abn	_____
Reflexes	☐ N ☐ Abn	_____
Head	☐ N ☐ Abn	_____
Neck	☐ N ☐ Abn	_____
Eyes	☐ N ☐ Abn	_____
Ears	☐ N ☐ Abn	_____
Nose	☐ N ☐ Abn	_____
Oral Cavity/Throat	☐ N ☐ Abn	_____
Lung	☐ N ☐ Abn	_____
Heart	☐ N ☐ Abn	_____
Pulses	☐ N ☐ Abn	_____
Abdomen	☐ N ☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Genitalia	☐ N ☐ Abn	_____
Back	☐ N ☐ Abn	_____
Hips	☐ N ☐ Abn	_____
Extremities	☐ N ☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Interpersonal violence (fighting, bullying)
☐ Living situation and food security
☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
☐ Connectedness with family and peers
☐ Connectedness with community
☐ School/work performance
☐ Coping with stress and decision making

Physical Health and Health Promotion
☐ Oral health
☐ Body image
☐ Healthy eating
☐ Physical activity and sleep

Emotional Well-being
☐ Mood regulation and mental health
☐ Sexuality

Risk Reduction
☐ Pregnancy and sexually transmitted infections
☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
☐ Acoustic trauma

Safety
☐ Seat belt and helmet use
☐ Driving
☐ Sun protection
☐ Firearm safety

☐ **Other**
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 17 and 20 years and/or high risk)***
☐ STI test *(if sexually active and/or high risk)*
☐ **HIV test *(once between 15 and 18 years, if sexually active and/ or high risk)***
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 16 years of age ☐ 17 years of age
☐ Other_____

☐ **Screen has been reviewed and is complete**

See page 1, school requirements for required signature

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

18, 19 and 20 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ N/A ☐ Parent ☐ Grandparent ☐ Other _____

Medical History

☐ Initial Screen ☐ Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your living situation_____

_____

Are you in school? ☐ No ☐ High school ☐ College/vocational

Working? ☐ Yes ☐ No _____

What are your future plans?_____

_____

What interests do you have outside of school and/or work? _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work

☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help

☐ Financial/money ☐ Emotional loss ☐ Health insurance

☐ Other_____

_____

_____

_____

Concerns and/or questions_____

_____

_____

_____

Traumatic Stress Reactions/PCL-C[1]

Positive screen = numbered responses 4 or greater

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all ☐ A little bit(1) ☐ Moderately(2) ☐ Quite a bit(3) ☐ Extremely(4)

Depression Screen/Patient Health Questionnaire (PHQ-2)

Positive screen = numbered responses 3 or greater

If Positive see Periodicity Schedule for link to PHQ-9

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Little interest or pleasure in doing things: ☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Risk Indicators (✓ *Check those that apply)*

☐ None identified ☐ *Tobacco use ☐ Cigarettes # per day_____

☐ E-Cigarettes ☐ *Chew ☐ Passive Smoke Risk

☐ *Alcohol use_____

☐ *Drug use (prescription or otherwise)_____

If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools

☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No

Are you sexually active? ☐ Yes ☐ No

Method of contraception _____

Do you have children? ☐ Yes ☐ No _____

_____

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No

Fruits/vegetables/lean protein per day_____

☐ Vitamins_____

☐ Normal elimination_____

☐ Physical activity/exercise an hour most days

Type of physical activity/exercise _____

Normal sleeping patterns? ☐ Yes ☐ No

Hours of sleep each night?_____

Oral Health

Date of last dental visit_____

Current oral health problems _____

Vision Acuity Screen: *(Subjective 18-20 years)*

R _____ L _____

Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective once between 18 and 20 years)*

20db@

R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ

L ear: _____ 6000HZ ____ 8000HZ

Wears hearing aids? ☐ Yes ☐ No

Continue on page 2

[1]Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594*. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34*, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 17 and 20 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV Risk**
☐ Low risk ☐ High risk
HIV test required once between 15 and 18 years

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____
_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
☐ Interpersonal violence
☐ Living situation and food security
☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
☐ Connectedness with family and peers
☐ Connectedness with community
☐ School/work performance
☐ Coping with stress and decision making

Physical Health and Health Promotion
☐ Oral health
☐ Body image
☐ Healthy eating
☐ Physical activity and sleep
☐ Transition to adult care

Emotional Well-being
☐ Mood regulation and mental health
☐ Sexuality

Risk Reduction
☐ Pregnancy and sexually transmitted infections
☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
☐ Acoustic trauma

Safety
☐ Seat belt and helmet use
☐ Driving and substance use
☐ Sun protection
☐ Firearm safety

☐ Other
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 17 and 20 years and/or high risk)***
☐ STI test *(if sexually active and/or high risk)*
☐ **HIV test *(once between 15 and 18 years, if sexually active and/ or high risk)***
☐ Other _____
_____

Referrals
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
_____

☐ Family Planning (FP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Transition to adult-oriented health care/medical home

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 19 years of age ☐ 20 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title